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CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

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AUTHORITY: Implementing and authorized by Articles III, IV, V and VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency expired July 29, 1995; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective November 28, 1995; amended at 20 Ill. Reg. 872, effective December 29, 1995; amended at 20 Ill. Reg. 7912, effective May 31, 1996; emergency amendment at 20 Ill. Reg. 9281, effective July 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 12510, effective September 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 15722, effective November 27, 1996; amended at 21 Ill. Reg. 607, effective January 2, 1997; amended at 21 Ill. Reg. 8386, effective June 23, 1997; emergency amendment at 21 Ill. Reg. 9552, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9822, effective July 2, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 10147, effective August 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13349, effective September 23, 1997; emergency amendment at 21 Ill. Reg. 13675, effective September 27, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 16161, effective November 26, 1997; amended at 22 Ill. Reg. 1408, effective December 29, 1997; amended at 22 Ill. Reg. 3083,

effective January 26, 1998; amended at 22 Ill. Reg. 11514, effective June 22, 1998; emergency amendment at 22 Ill. Reg. 13070, effective July 1, 1998, for a maximum of 150 days; emergency amendment at 22 Ill. Reg. 15027, effective August 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16273, effective August 28, 1998; amended at 22 Ill. Reg. 21490, effective November 25, 1998; amended at 23 Ill. Reg. 5784, effective April 30, 1999; amended at 23 Ill. Reg. 7115, effective June 1, 1999; amended at 23 Ill. Reg. 7908, effective June 30, 1999; emergency amendment at 23 Ill. Reg. 8213, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12772, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13621, effective November 1, 1999; amended at 24 Ill. Reg. 2400, effective February 1, 2000; amended at 24 Ill. Reg. 3845, effective February 25, 2000; emergency amendment at 24 Ill. Reg. 10386, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 11846, effective August 1, 2000; amended at 24 Ill. Reg. 16067, effective October 16, 2000; amended at 24 Ill. Reg. 17146, effective November 1, 2000; amended at 24 Ill. Reg. 18293, effective December 1, 2000; amended at 25 Ill. Reg. 5359, effective April 1, 2001; emergency amendment at 25 Ill. Reg. 5432, effective April 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 6959, effective June 1, 2001; emergency amendment at 25 Ill. Reg. 9974, effective July 23, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 10513, effective August 2, 2001; emergency amendment at 25 Ill. Reg. 12870, effective October 1, 2001, for a maximum of 150 days; emergency expired February 27, 2002; amended at 25 Ill. Reg. 16087, effective December 1, 2001; emergency amendment at 26 Ill. Reg. 536, effective December 31, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 680, effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 4825, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 4953, effective March 18, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 7786, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 7340, effective April 30, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 8395, effective May 28, 2002; emergency amendment at 26 Ill. Reg. 11040, effective July 1, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16612, effective October 22, 2002; amended at 26 Ill. Reg. 12322, effective July 26, 2002; amended at 26 Ill. Reg. 13661, effective September 3, 2002; amended at 26 Ill. Reg. 14808, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 14887, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17775, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 580, effective January 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 866, effective January 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 4386, effective February 24, 2003; emergency amendment at 27 Ill. Reg. 8320, effective April 28, 2003, for a maximum of 150 days; emergency amendment repealed at 27 Ill. Reg. 12121, effective July 10, 2003; amended at 27 Ill. Reg. 9178, effective May 28, 2003; emergency amendment at 27 Ill. Reg. 11041, effective July 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16185, effective October 1, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16268, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18843, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 1418, effective January 8, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 1766, effective January 10, 2004, for a maximum of 150 days; emergency expired June 7, 2004;

amended at 28 Ill. Reg. 2770, effective February 1, 2004; emergency amendment at 28 Ill. Reg. 5902, effective April 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7101, effective May 3, 2004; amended at 28 Ill. Reg. 8072, effective June 1, 2004; emergency amendment at 28 Ill. Reg. 8167, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9661, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10157, effective July 1, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 12036, effective August 3, 2004, for a maximum of 150 days; emergency expired December 30, 2004; emergency amendment at 28 Ill. Reg. 12227, effective August 6, 2004, for a maximum of 150 days; emergency expired January 2, 2005; amended at 28 Ill. Reg. 14557, effective October 27, 2004; amended at 28 Ill. Reg. 15536, effective November 24, 2004; amended at 29 Ill. Reg. 861, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2026, effective January 21, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 5514, effective April 1, 2005; emergency amendment at 29 Ill. Reg. 5756, effective April 8, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 11622, effective July 5, 2005, for the remainder of the 150 days; amended at 29 Ill. Reg. 8363, effective June 1, 2005; emergency amendment at 29 Ill. Reg. 10275, effective July 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12568, effective August 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 15629, effective October 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 19973, effective November 23, 2005; amended at 30 Ill. Reg. 383, effective December 28, 2005; emergency amendment at 30 Ill. Reg. 596, effective January 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 955, effective January 9, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 2827, effective February 24, 2006; emergency amendment at 30 Ill. Reg. 7786, effective April 10, 2006, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 12400, effective July 1, 2006, for the remainder of the 150 days; emergency expired September 6, 2006; amended at 30 Ill. Reg. 8877, effective May 1, 2006; amended at 30 Ill. Reg. 10393, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11815, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18672, effective November 27, 2006; emergency amendment at 31 Ill. Reg. 1602, effective January 1, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 1997, effective January 15, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 5596, effective April 1, 2007; amended at 31 Ill. Reg. 8123, effective May 30, 2007; amended at 31 Ill. Reg. 8508, effective June 1, 2007; emergency amendment at 31 Ill. Reg. 10137, effective July 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11688, effective August 1, 2007; amended at 31 Ill. Reg. 14792, effective October 22, 2007; amended at 32 Ill. Reg. 312, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 518, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 2993, effective February 16, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 8718, effective May 29, 2008; amended at 32 Ill. Reg. 9945, effective June 26, 2008; emergency amendment at 32 Ill. Reg. 10517, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 33 Ill. Reg. 501, effective December 30, 2008; peremptory amendment at 33 Ill. Reg. 1538, effective December 30, 2008; emergency amendment at 33 Ill. Reg. 5821, effective April 1, 2009, for a maximum of 150 days; emergency expired August 28, 2009; amended at 33 Ill. Reg. 13246, effective September 8, 2009;

emergency amendment at 34 Ill. Reg. 15856, effective October 1, 2010, for a maximum of 150 days; emergency expired February 27, 2011; amended at 34 Ill. Reg. 17737, effective November 8, 2010; amended at 35 Ill. Reg. 420, effective December 27, 2010; expedited correction at 38 Ill. Reg. 12618, effective December 27, 2010; amended at 35 Ill. Reg. 10033, effective June 15, 2011; amended at 35 Ill. Reg. 16572, effective October 1, 2011; emergency amendment at 36 Ill. Reg. 10326, effective July 1, 2012 through June 30, 2013; emergency amendment to Section 148.70(g) suspended at 36 Ill. Reg. 13737, effective August 15, 2012; suspension withdrawn from Section 148.70(g) at 36 Ill. Reg. 18989, December 11, 2012; emergency amendment in response to Joint Committee on Administrative Rules action on Section 148.70(g) at 36 Ill. Reg. 18976, effective December 12, 2012 through June 30, 2013; emergency amendment to Section 148.140(b)(1)(F) suspended at 36 Ill. Reg. 13739, effective August 15, 2012; suspension withdrawn from Section 148.140(b)(1)(F) at 36 Ill. Reg. 14530, September 11, 2012; emergency amendment to Sections 148.140(b) and 148.190(a)(2) in response to Joint Committee on Administrative Rules action at 36 Ill. Reg. 14851, effective September 21, 2012 through June 30, 2013; amended at 37 Ill. Reg. 402, effective December 27, 2012; emergency rulemaking at 37 Ill. Reg. 5082, effective April 1, 2013 through June 30, 2013; amended at 37 Ill. Reg. 10432, effective June 27, 2013; amended at 37 Ill. Reg. 17631, effective October 23, 2013; amended at 38 Ill. Reg. 4363, effective January 29, 2014; amended at 38 Ill. Reg. 11557, effective May 13, 2014; amended at 38 Ill. Reg. 13263, effective June 11, 2014; amended at 38 Ill. Reg. 15165, effective July 2, 2014; emergency amendment at 39 Ill. Reg. 10453, effective July 10, 2015, for a maximum of 150 days; emergency expired December 6, 2015; amended at 39 Ill. Reg. 10824, effective July 27, 2015; amended at 39 Ill. Reg. 16394, effective December 14, 2015; amended at 41 Ill. Reg. 1041, effective January 19, 2017; amended at 42 Ill. Reg. 3152, effective January 31, 2018; emergency amendment at 42 Ill. Reg. 13740, effective July 2, 2018, for a maximum of 150 days; emergency amendment to emergency rule at 42 Ill. Reg. 16318, effective August 13, 2018, for the remainder of the 150 days; emergency expired November 28, 2018; amended at 42 Ill. Reg. 22401, effective November 29, 2018; emergency amendment at 43 Ill. Reg. 9813, effective August 26, 2019, for a maximum of 150 days; amended at 44 Ill. Reg. 2545, effective January 22, 2020; emergency amendment at 44 Ill. Reg. 12832, effective July 17, 2020, for a maximum of 150 day; amended at 44 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 148.50 Covered Hospital Services

Effective for dates of outpatient services on or after July 1, 2014 and inpatient discharges on or after July 1, 2014, unless a later effective date is specified in this Section:

a) The Department shall pay hospitals for the essential provision of inpatient, outpatient, and clinic diagnostic and treatment services not otherwise excluded or limited that are provided by a hospital, as described in Section 148.25(b), or a distinct part unit, as described in Section 148.25(c), and that are provided in compliance with hospital licensing standards. Payment may be made for the

following types of care subject to the special requirements described in Section 148.40:

1) General/specialty services.

2) Psychiatric services.

3) Rehabilitation services.

4) End-Stage Renal Disease Treatment (ESRDT) services.

b) Certain services are defined as hospital covered services with certain restrictions. These programs include hospital residing long term care services, subacute alcoholism and substance abuse treatment services, and the transplant program.

c) Hospital ~~Residing~~ Long Term Care Services

1) Effective for dates of service on or after July 1, 2019, Hospital Long Term Care Days shall be covered. Hospital Long Term Care Days are defined as days when:

A) The discharging hospital or the assigned peer review agent determines that continued hospital level of care is no longer necessary, and

B) Discharge of the patient is delayed due to the lack of available placement outside of the hospital at the next level of care provided in a nursing facility, ICF/DD facility, MC/DD facility, rehabilitation hospital, psychiatric hospital, Long-Term Services and Supports Waiver setting, or a residence when home health care services (as defined in Section 140.471) are required.

~~Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long term care:~~

~~A)~~ ~~A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or~~

~~B)~~ ~~A special unit or separate facility administratively associated with the hospital and licensed as a long term care facility.~~

2) For dates of service on or after July 1, 2019, Hospital Long Term Care Days shall be reimbursed in accordance with this subsection (c). Hospitals are required to notify the Department when post-discharge placement is required. Approval from the Department that the stay meets the requirements of this subsection is required before payment can be made. In order to approve payment for Hospital Long Term Care Days, documentation demonstrating the following shall be provided:~~There are three categories of service for hospital residing long term care. These categories are as follows:~~

A) The hospital attempted to place the individual in at least five appropriate settings;~~Skilled Care – Hospital Residing (category of service 037) Reimbursement is available for hospitals providing hospital residing long term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:~~

~~i)~~ ~~The hospital must document its attempt to place the patient in at least five appropriate facilities.~~

~~ii)~~ ~~Documentation (form HFS 3127) must be attached to the appropriate claim form and submitted to the Department.~~

~~iii)~~ ~~Reimbursement is limited to services provided after the minimum number of contacts has been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.~~

B) Following the five placement attempts, the hospital notified the

Department or its designated contractor of its inability to place the individual;~~Exceptional Care – Hospital Residing (category of service 038) Reimbursement is available for hospitals providing hospital residing long term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for the reimbursement, the following criteria must be met:~~

~~i) The hospital must document its attempt to place the patient in at least five appropriate facilities.~~

~~ii) Documentation (form HFS 3127) must be attached to the appropriate claim form and submitted to the Department.~~

~~iii) Reimbursement is limited to services provided after the minimum number of contacts has been made. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.~~

C) The individual requires the level of care described in subsection (c)(1)(B).~~ID/MI Non-Acute Care – Hospital Residing (category of service 039) Reimbursement is available for hospitals providing hospital residing long term care when the pre-admission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide rate for intermediate care facilities for persons with intellectual disabilities. For a hospital to be eligible for such reimbursement, the following criteria must be met:~~

~~i)~~ ~~The hospital must document that the pre-admission screening agent has not completed the assessment, planning or discharge process.~~

~~ii)~~ ~~Reimbursement is limited to a maximum of three non-acute level of care days. Reimbursement will not be made for services which were billed as acute inpatient care and denied as not being medically necessary.~~

3) Reimbursement is limited to services provided after the minimum number of contacts have been made and the Department or its contractor have been notified of the need for post-discharge placement. For dates of service on or after July 1, 2019 and prior to November 1, 2020, the Department will not limit reimbursement to days after the Department or its contractor have been notified of the need for post placement discharge and approved payment; however, the hospital still must provide documentation that the requirements of (c)(2)(A) and (C) are met.

4) Reimbursement Limitations.

A) Reimbursement will not be made for services where the underlying inpatient stay was denied as not medically necessary.

B) When the initial hospital stay is reimbursed under the DRG system, only days that exceed the DRG average length of stay can qualify as Hospital Long Term Care Days.

C) When a hospital is reimbursed on a per diem basis, only days beyond the period of time where hospital level of care is needed can qualify as Hospital Long Term Care Days.

D) Services reimbursable under 305 ILCS 5/5-5.07 shall not be reimbursed as Hospital Long Term Care Days.

E) Services reimbursable under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act and certified as part of a continued stay review by the Department's Quality Improvement Organization shall not be reimbursed as Hospital Long Term Care Days.

5) The reimbursement rate for each eligible Hospital Long Term Care Day is $289.48 per day.

6) Payments for Hospital Long Term Care Days are not eligible for per diem add-on payments under the Medicaid High Volume Adjustment (MHVA) and Medicaid Percentage Adjustment (MPA) programs.

7) If a hospital seeks reimbursement for services provided to any individual enrolled in a Managed Care Organization (MCO), the requirements of Section 14-13(e) of the Public Aid Code [305 ILCS 5] must be followed.

d) Subacute Alcoholism and Substance Abuse Treatment Services
Rules regarding reimbursement for sub-acute alcoholism and substance abuse treatment services may be found under Sections 148.340 through 148.390.

e) Transplant Program
The Medical Assistance Program provides for payment for organ transplants only when provided by a certified transplantation center as described in Section 148.82. Payment for kidney and cornea transplants does not require enrollment as an approved transplantation center.

(Source: Amended at 44 Ill. Reg. _____, effective _____)

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.122 Medicaid Percentage Adjustments

Effective for dates of service on or after July 1, 2014, the Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1 of each year unless otherwise noted.

a) Qualified Medicaid Percentage Hospitals. The Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital, except those that are owned or operated by a unit of government, may qualify for a Medicaid Percentage Adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section 148.120(i)(4), is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section 148.120(i)(3).

2) The hospital's low income utilization rate, as defined in Section 148.120(i)(6), exceeds 25 per centum.

3) Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section 148.120(i)(4), that was at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3), and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (see 77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (see 42 CFR 5 (1989)).

4) Illinois hospitals that meet the following criteria:

A) Have an MIUR, as defined in Section 148.120(i)(4), that is at least the mean Medicaid inpatient utilization rate, as defined in Section 148.120(i)(3).

B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(3), that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (g)(2).

5) Any children's hospital, as defined in Section 148.25(d)(3).

6) Out of state hospitals meeting the criteria in Section 148.120(e).

b) In making the determination described in subsections (a)(1) and (a)(4)(A), the Department shall utilize the data described in Section 148.120(c) and received in compliance with Section 148.120(f).

c) Hospitals that qualified as a Medicaid Percentage Adjustment hospital under subsection (a)(2) for the Medicaid percentage determination year beginning October 1, 2013 may apply annually to become qualified under subsection (a)(2) by submitting audited certified financial statements as described in Section 148.120(d) and received in compliance with Section 148.120(f).

d) Medicaid Percentage Adjustments. The adjustment payments required by subsection (a) of this Section for qualified hospitals shall be calculated annually as follows for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section 148.25(a).

1) The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section 148.120(i)(4), and subject to subsection (e) of this Section, as follows:

A) Hospitals with an MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

B) Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;

C) Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

D) Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

2) The Medicaid Percentage Adjustment payment, calculated in accordance with this subsection (d), to a hospital shall not exceed $155 per day for a children's hospital, as defined in Section 148.25(d)(3), and shall not exceed $215 per day for all other hospitals.

3) The amount calculated pursuant to subsections (d)(1) through (d)(2) of this Section shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) hospital cost index from DSH determination year 1993, as defined in Section 148.120(i)(2), through DSH determination year 2003 and annually thereafter, by a percentage equal to the lesser of:

A) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

B) The percentage increase in the Statewide average hospital payment rate, over the previous year's Statewide average hospital payment rate.

4) The amount calculated pursuant to subsections (d)(1) through (d)(3) shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under subsections (d)(1) through (d)(3) shall be paid on a per diem basis and shall be applied to each covered day of care provided.

e) Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section 148.25(d)(3), the payment adjustment calculated under subsection (d)(1) shall be multiplied by 2.0.

f) Medicaid Percentage Adjustment Limitations~~.~~

1) In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform ~~non-emergency~~ obstetric services~~procedures~~ at the hospital. This requirement for obstetric services does not apply to a hospital:

A) In~~in~~ which the inpatients are predominantly individuals under 18 years of age;~~, or~~

B) That does not offer non-emergency obstetric services as of December 22, 1987; or

C) That was providing obstetric services prior to February 1, 2019 and discontinues obstetric services after February 1, 2019 and is located within 15 miles of a hospital that continues to provide obstetric services at the time of discontinuation. Hospitals that do not offer obstetric services~~non-emergency obstetrics~~ to the general public, with the exception of those hospitals described in Section 148.25(d), must submit a statement to that effect that includes the date obstetric services were discontinued.

2) Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of obstetric services~~non-emergency~~

~~obstetrical care~~. The provisions of this subsection (f)(2) shall not apply to those hospitals described in Section 148.25(d) or those hospitals that have not offered obstetric~~non-emergency obstetrical~~ services as of December 22, 1987, or those hospitals that discontinue obstetric services after February 1, 2019 and are located within 15 miles of a hospital that continues to provide obstetric services at the time of discontinuation. In this instance, the adjustments calculated under subsection (d) shall cease to be effective on the date that the hospital discontinued the provision of obstetric services~~non-emergency obstetrical care~~.

3) Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), that result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.

4) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section 148.120(i)(4), is less than one percent.

g) Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:

1) "Medicaid Percentage determination year" has the same meaning as the DSH determination year defined in Section 148.120(i)(2).

2) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4), provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in subsection (g)(6), for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid

percentage determination year and contained within the Department's paid claims data base.

3) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (g)(4), provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (g)(6), provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.

4) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage Adjustment determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act (specifically excluding Medicare/Medicaid crossover claims), with a Diagnosis Related Grouping (DRG) of:

A) 370 through 375 for claims adjudicated before July 1, 2014; or

B) 540, 541, 542 or 560 for claims adjudicated on or after July 1, 2014.

5) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3), means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

6~~7~~) "Medicaid obstetrical inpatient utilization rate base year" means, for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year; etc.

7~~8~~) "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

(Source: Amended at 44 Ill. Reg. _____, effective _____)

Section 148.190 Copayments

The following implements cost sharing in compliance with 42 USC 1396o (section 1916 of the Social Security Act):

a) With the exception of those classes of individuals identified in 89 Ill. Adm. Code 140.402(d) and those services identified in 89 Ill. Adm. Code 140.402(e), copayments will be assessed on inpatient services provided under all Medical Assistance Programs administered by the Department, as provided in the Illinois Public Aid Code [305 ILCS 5]. Effective July 1, 2012 through August 31, 2019, copayments will be in the following amounts:

1) Inpatient hospital services: a daily copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013 through August 31, 2019, the nominal copayment amount is $3.90.

2) Non-emergency services defined as Non-emergency/Screening Level in Section 148.140(b) rendered in an emergency room: a nominal copayment amount as defined in federal regulations at 42 CFR 447.50 et seq., which, for dates of service beginning July 1, 2012 through March 31, 2013, is $3.65. Beginning April 1, 2013 through August 31, 2019, the nominal copayment amount is $3.90.

b) In each instance where a copayment is payable, the Department will reduce the amount payable to the affected provider by the amount of the required copayment.

c) No provider may deny care or services on account of an individual's inability to pay a copayment; this requirement, however, shall not extinguish the liability for payment of the copayment by the individual to whom the care or services were furnished.

(Source: Amended at 44 Ill. Reg. _____, effective _____)